UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF TENNESSEE

MCKEE FOODS CORPORATION, Plaintiff, v. STATE OF TENNESSEE, Intervenor, v. BFP INC. d/b/a THRIFTY MED PLUS PHARMACY, Defendant.	)	Case No: 1:21-cv-00279-CEA-SKL Judge Atchley Magistrate Judge Lee

DECLARATION OF ANGELA SHARPS

Pursuant to 28 U.S.C. §1746, the undersigned, Angela Sharps, declares as follows:

1. My name is Angela Sharps. I am over 18 years old, am fully competent to provide this Declaration, and have personal knowledge of the matters stated herein.

2. I am employed by McKee Foods Corporation ("McKee Foods") as Compensation and Benefits Manager. In my position, I am responsible for the oversight and management of McKee Foods' compensation and benefit programs, including the McKee Foods Corporation Employees Health and Supplemental Benefits Plan ("McKee Health Plan"). I also supervise McKee Foods staff who are involved in the day-to-day administration of the company's benefit programs and interact with McKee Foods employees and third parties in matters pertaining to the company's benefit programs. I am a custodian of the records of McKee Foods' Compensation and Benefits Department, which records are kept in the course of the department's regularly conducted business activities.

Exhibit 2

3. Attached to this declaration as **Exhibit A** is a true and correct copy of the McKee Health Plan Document and Summary Plan Description, including its Attachment B (Prescription Drug Program). For sake of brevity, I have not attached the summary plan descriptions for the various other programs listed on page 35 of the Plan Document since those programs are not at issue in this litigation.

4. McKee Foods is the sponsor, administrator, and fiduciary of the McKee Health Plan which is governed by the Employee Retirement Income Security Act of 1974 ("ERISA"). Benefits under the McKee Health Plan are not covered or provided by insurance but are completely self-funded by contributions from McKee Foods and plan participants.

5. Among other benefits, the McKee Health Plan offers prescription drug benefits (see Exhibit A, Attachment B) to several thousand eligible employees and their eligible dependents located in multiple jurisdictions throughout the United States. In addition to their Tennessee employees, McKee Foods and its wholly owned subsidiary, McKee Foods Transportation, LLC, have significant numbers of employees, most with plan-eligible dependents, at manufacturing and transportation facilities in Arkansas and Virginia and a distribution center in Kingman, Arizona. In addition, McKee Foods employs hundreds of plan-eligible field sales personnel (most with eligible dependents) who are located in every state within the continental United States. Currently, the McKee Health Plan has a total of approximately 6,500 participants (employees and dependents) who live *outside* the State of Tennessee.

6. The prescription drug benefits provided under the McKee Health Plan are administered by a pharmacy benefit manager which contracts with various pharmacies to provide prescription drug services to McKee Health Plan participants. The contracted pharmacies

comprise the pharmacy plan network from which McKee Health Plan participants may obtain prescription drugs. McKee Foods and the pharmacy benefit manager determine which pharmacies are included in the plan network and likewise determine which pharmacies will remain in or be removed from the pharmacy network.

7. MedImpact Healthcare Systems, Inc. ("MedImpact"), became the pharmacy benefit manager for the McKee Health Plan effective January 2019. Before that date, Magellan Rx Management ("Magellan") was the pharmacy benefit manager for the McKee Health Plan.

8. Prior to July 1, 2019, Thrifty Med Plus Pharmacy ("Thrifty Med") was included in the McKee Health Plan's pharmacy network. In 2018, a plan participant made a complaint against Thrifty Med after discovering that the pharmacy, after filling a prescription for a 90-day supply of medication, changed the prescription, for billing purposes, to three 30-day supplies. The plan participant further reported that without her knowledge or permission, Thrifty Med personnel had signed the participant's name to prescription logs at the pharmacy, incorrectly indicating that the participant had picked up the 30-day supplies of medication on dates when the participant was not present in the store.

9. Magellan was the pharmacy benefit manager at the time. Magellan's Special Investigations Unit ("SIU") conducted an investigation of the complaint described above and commissioned an audit of Thrifty Med's billing practices. Magellan reported the findings of the investigation and audit to me in May 2019. The results of the audit led me and McKee Foods to conclude that Thrifty Med had engaged in improprieties in processing prescriptions and had overcharged the McKee Health Plan and its participants.

10. McKee Foods and MedImpact jointly made the decision to remove Thrifty Med from the McKee Health Plan's pharmacy network. That decision was communicated to Thrifty

Med in a Notice of Network Termination dated June 3, 2019 (copy attached as **Exhibit B**). The termination was effective July 1, 2019. Cause for Thrifty Med's removal from the network was not required, and none was specified in the Notice of Network Termination.

11. Thrifty Med has continued to demand reinstatement to the McKee Health Plan pharmacy network. McKee Foods and MedImpact are opposed to Thrifty Med's reinstatement.

I declare under penalty of perjury under the laws of the United States and the State of Tennessee that the foregoing is true and correct.

Executed on May 22, 2022.

Angela L Sharps

ANGELA SHARPS

EXHIBIT A

MCKEE FOODS CORPORATION
EMPLOYEES HEALTH AND SUPPLEMENTAL BENEFITS PLAN

PLAN DOCUMENT
AND
SUMMARY PLAN DESCRIPTION

AMENDED AND RESTATED AS OF JANUARY 1, 2019

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INTRODUCTION

McKee Foods Corporation ("McKee Foods") maintains the McKee Foods Corporation Employees Health and Supplemental Benefit Plan (the "Plan") for the exclusive benefit of its eligible employees, the eligible employees of the Adopting Employers, and their eligible family members.

The Plan provides health and welfare benefits through the following component benefit programs:

- Medical program
- Prescription drug program
- Health reimbursement arrangement ("HRA")
- Wellness program
- Dental program
- Vision program
- Employee assistance program ("EAP")
- Critical illness program
- Group accident program
- McKeeFlex
- Prairie City Bakery, LLC Section 125 Flexible Spending Program

Each of the component benefit programs is more fully described in one of the Attachments. Each component benefit program has its own requirements for eligibility and enrollment, which are set forth in this document and the Attachments.

This document (the "Base Plan"), together with the Attachments, is the plan document for the Plan, as well as the Plan's summary plan description as described in ERISA § 102. Except where otherwise expressly provided in the Base Plan or as necessary to comply with the law, in the event of any inconsistency between the Base Plan and the Attachments, the provisions of the Attachments shall control.

DEFINITIONS

"Adopting Employer" or "Participating Employer" means an entity that has adopted the Plan and/or the component benefit program(s), as applicable, with the permission of the Plan Administrator, in accordance with the provisions described in the "ADOPTION, AMENDMENT, AND TERMINATION" section of the Plan.

"Affordable Care Act" means the Patient Protection and Affordable Care Act, as amended.

"Attachments" means the evidence of coverage (EOC), insurance certificate booklets, and other plan documents and summaries included in the section titled Attachments. These documents are incorporated and made a part of this Plan document and SPD.

"COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

"Code" means the Internal Revenue Code of 1986, as amended.

"Covered Entity" means a health plan, a health care clearinghouse, or a health care provider that transmits any health information in electronic form in connection with a transaction covered by Subchapter A of 45 C.F.R. Subtitle A.

"Dependent" means a Participant's Spouse and any individual who qualifies as a Participant's "dependent" under the terms of any component benefit program.

"Employer" means McKee Foods Corporation and any Adopting Employer.

"ERISA" means the Employee Retirement Income Security Act of 1974, as amended.

"McKeeFlex Plan" means the McKee Foods Corporation Section 125 Flexible Spending Plan.

"FMLA" means the Family and Medical Leave Act of 1993.

"Group Health Plan" means a component benefit program that is an employee welfare benefit plan, to the extent that the plan provides medical care (as defined in Section 733(a)(2) of ERISA) to Participants or their Dependents directly or through insurance, reimbursement, or otherwise.

"HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended.

"Participant" means an employee who has met the eligibility provisions of one or more component benefit programs. A Participant may be referred to as a Member, Subscriber, or Insured in any particular component benefit program.

"PHI" or "Protected Health Information" means information collected from an individual and genetic information, whether oral or recorded, that (1) is maintained or transmitted in any form or medium, including electronic media; (2) is created or received by the Plan; (3) relates to the past, present, or future physical or mental health condition of a Participant, the provision of health care to a Participant, or the past, present, or future payment for health care; and (4) that identifies the Participant or for which there is a reasonable basis to believe the PHI can be used to identify the Participant.

"Plan" means this McKee Foods Corporation Employees Health and Supplemental Benefits Plan, including all Attachments.

"Plan Administrator" means McKee Foods Corporation.

"Plan Sponsor" means McKee Foods Corporation.

"QMCSO" means a qualified medical child support order, as defined in Section 609(a) of ERISA.

"Rescission" means the retroactive cancellation of coverage under a Group Health Plan for reasons other than: (1) the failure to pay required premiums; or (2) such other reasons as may be set forth in applicable guidance, such as retroactive cancellation due to reconciling lists of eligible employees and retroactive cancellation due to failure to notify the Plan Administrator in the event of divorce.

"Spouse" means an individual who qualifies as a Participant's "spouse" under the terms of any component benefit program.

"USERRA" means the Uniformed Services Employment and Reemployment Rights Act of 1994.

ELIGIBILITY AND ENROLLMENT

Eligibility

Employees and their Dependents are eligible to participate in the Plan if they are eligible to participate in any one or more of the component benefit programs described in the Attachments.

The Plan Administrator's determination of eligibility under the terms of the Plan shall be final and conclusive.

Initial Enrollment

Employees who meet the eligibility provisions outlined above may enroll themselves and any eligible Dependents in one or more component benefit programs at any time during their first sixty (60) days of employment. If an employee provides all requested information and documents, and timely submits an enrollment request, coverage will become effective on the employee's sixty-first (61st) day of employment.

Annual Enrollment

If an employee who meets the eligibility provisions outlined above does not enroll within the employee's initial enrollment period described above, or would like to make changes in the coverage previously selected, the employee may make changes during an Annual Enrollment period. Employees will be notified prior to the start of each Plan Year when the Plan Year's Annual Enrollment period will open and close. Annual Enrollment elections will take effect on January 1of the following plan year.

Special Enrollment Rights

An employee who meets the eligibility requirements described above and who declined coverage during his initial enrollment period or an Annual Enrollment period may enroll himself and/or his Dependents in a component benefit program that is a Group Health Plan if: (1) the individual seeking enrollment declined coverage under this Plan because he had coverage in another group health plan and coverage under the other group health plan was subsequently lost; (2) since declining coverage, the employee has acquired a new Dependent (through marriage, birth, adoption, or placement for adoption); or (3) the individual seeking enrollment becomes eligible for a premium assistance subsidy for, or loses eligibility under, a Medicaid plan under Title XIX of the Social Security Act or under a state child health insurance plan. Enrollment must be requested within thirty (30) days of the event that gives rise to the special enrollment right if the event is described in (1) or (2) of the previous sentence; enrollment must be requested within sixty (60) days of the event that gives rise to the special enrollment right if the event is described in (3) of the previous sentence.

Qualified Medical Child Support Orders ("QMCSOs")

An employee's non-custodial child may be eligible to receive Group Health Plan benefits under a QMCSO. The Plan has procedures for determining whether an order qualifies as a QMCSO. A copy of these procedures may be obtained at any time from the Plan Administrator.

Termination of Participation

A Participant or Dependent shall cease participation in the Plan on the earliest to occur of the following events:

1. The Plan is terminated with respect to the Participant or Dependent.
2. The Participant or Dependent ceases to meet the eligibility requirements described above.
3. The Participant's or Dependent's death.
4. The Participant's termination of employment.
5. The Participant or Dependent requests to cease participation, either during an Annual Enrollment period or due to certain qualifying status changes.

If a Participant or Dependent experiences a loss of coverage under a Group Health Plan, the Participant or Dependent may be eligible for rights under COBRA. See the "COBRA" section below.

BENEFITS

Each component benefit program may offer a selection of benefits and a selection of coverage options from which Participants may choose. This may include different coverage levels, such as employee only, employee + spouse, employee + child(ren), and family. Certain component benefit programs may be separately elected, while others may only be elected in conjunction with other component benefit programs, as more fully described in the applicable Attachments. This is true for all actively employed Participants and their Dependents, as well as COBRA beneficiaries.

The cost of coverage may vary depending on which coverage option the Participant selects. The cost of the benefits provided through the component benefit programs may be funded entirely by employee contributions, entirely by contributions from McKee, or in part by contributions from McKee and in part by employee contributions. Employee contributions may be pre-tax or after-tax, subject to the terms of the McKeeFlex cafeteria plan and applicable component benefit program. McKee will communicate the Participant's share of the cost for benefits provided through each component benefit program during Annual Enrollment each year, or more often as McKee determines is necessary.

Participants will have the opportunity to enroll in the component benefit programs when they first become eligible and at least once per year thereafter, as described in the "ELIGIBILITY AND ENROLLMENT" section above.

Generally, Participants may only change their benefit elections during McKee's Annual Enrollment. However, Participants may be permitted to change their benefit elections, including the amount of their pre-tax contributions, if they experience certain qualifying changes. See the "ELIGIBILITY AND ENROLLMENT" section of this document and the McKeeFlex Plan document for more information.

ADMINISTRATION

Plan Administrator

McKee Foods Corporation is the Plan Administrator. The Plan Administrator may delegate to one or more persons or committees the authority to perform all or some of the Plan Administrator's duties. If a component benefit program names an administrator other than McKee Foods Corporation for some or all administration functions, such administrator shall assume the delegated duties of the Plan Administrator for that component benefit program.

The Plan Administrator and its designee shall administer the Plan in accordance with its terms and shall establish its policies, interpretations, practices, and procedures. The Plan Administrator and its designee shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues that relate to eligibility to participate in the Plan and that relate to eligibility for benefits, to decide disputes that may arise relative to a Participant's rights, to decide questions of Plan interpretation and those of fact relating to the Plan, and to decide all questions regarding any claim for benefits under the Plan. The decisions of the Plan Administrator and its designee will be final and binding upon all interested parties.

Duties of the Plan Administrator

The Plan Administrator and its designee shall have the following duties and responsibilities:

1. To administer the Plan in accordance with its terms;
2. To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies, mistakes, or omissions;
3. To decide disputes that may arise relative to a Participant's rights under the Plan;
4. To prescribe procedures for filing a claim for benefits and for the review of claim denials;
5. To keep and maintain the Plan documents and all other records pertaining to the Plan;
6. To appoint a claims administrator to pay claims;
7. To perform all necessary reporting as required by ERISA;
8. To establish and communicate procedures to determine whether a medical child support order is qualified under ERISA;
9. To delegate to any person or entity such powers, duties, and responsibilities as it deems appropriate; and
10. To require any person to furnish such reasonable information as the Plan Administrator may request for the administration of the Plan as a condition to receiving any benefits under the Plan.

Plan Administrator Compensation

The Plan Administrator serves without compensation. However, all expenses for Plan administration, including compensation for hired services, will be paid by the Plan.

Plan Testing

To the extent permitted under the Code and ERISA, populations of employees participating in the Plan and its component benefit programs may be disaggregated for purposes of nondiscrimination testing.

ADOPTION, AMENDMENT, AND TERMINATION

Adoption by an Adopting Employer

Any Adopting Employer may adopt the Plan for the benefit of its eligible Employees if: (1) the Board of Directors of McKee Foods Corporation authorizes such adoption by resolution and delivers to the Plan Administrator a certified copy of such resolution; and (2) the Board of Directors of the Adopting Employer authorizes such adoption by resolution and delivers to McKee Foods Corporation and the Plan Administrator a certified copy of such resolution.

By adopting this Plan, the Adopting Employer shall become a party to the Plan and shall become an "Employer" as defined in the "DEFINITIONS" section of this Plan. Each Employer shall pay for its allocable share of the claims costs and of the expenses of the administration of the Plan so long as it remains a party to the Plan. The Plan Administrator shall maintain separate accountings for each Employer and its Participants, but no segregation of assets shall be required.

No Employer shall make any contribution on behalf of any other Employer or to or for the benefit of Participants of any other Employer.

Unless specifically approved by the Board of Directors of the McKee Foods Corporation, an Adopting Employer will adopt the Plan, including all component benefit programs included as Attachments, as a whole; however, if approved by the Board of Directors of McKee Foods Corporation, an Adopting Employer may adopt the Plan and only one or more, but not all, component benefit programs of the Plan.

Amendment and Termination

The Plan Sponsor intends to maintain this Plan, as amended from time to time, indefinitely. However, it reserves the right, at any time, to amend, suspend, or terminate the Plan in whole or in part. Any such amendment, suspension, or termination shall be communicated to Participants in the Plan (to the extent required by applicable law) and to the Adopting Employers. The right to change the Plan includes, but is not limited to, amending the Plan to terminate the participation of any Adopting Employer as of any prospective date, amending the eligibility provisions of the Plan, and amending the component benefit programs available under the Plan.

Upon appropriate action, any Adopting Employer may terminate its participation in the Plan, in which event any funds of the Plan held for the Participants of such Adopting Employer shall be applied first to pay all benefits owed to Participants under the Plan, then to offset any administrative expenses related to the Plan. If the Plan is terminated, the rights of the Participants are limited to expenses incurred before termination.

Any amendment that is necessary to bring this Plan into conformity with the law may be made retroactively.

The Attachments to the Plan may be updated and amended from time-to-time without the need for formal amendment of the Plan document.

NOTICE OF COBRA CONTINUATION RIGHTS

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

Benefits Not Eligible for Continuance

Life insurance, accidental death and dismemberment benefits and weekly income disability or supplemental health insurance benefits are not eligible for continuance of COBRA.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;

- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

You Must Give Notice of Some Qualifying Events

For the other Qualifying Events (divorce or legal separation of the Employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the Qualifying Event occurs. You must provide this notice to the McKee Foods Corporation Group Insurance Department by completing and submitting a "Health Benefits Request for Change" form.

A dependent Qualified Beneficiary may submit valid legal document(s) to the McKee Foods Corporation Group Insurance Department in place of the form. The documents must enable the Plan Administrator to determine that a Qualifying Event has occurred and identify the Qualified Beneficiaries. Additional legal documentation may be requested by the Plan Administrator.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the Qualifying Event is the death of the Employee, the Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), Your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the Qualifying Event is the end of employment or reduction of the Employee's hours of employment, and the Employee became entitled to Medicare benefits less than 18 months before the Qualifying Event, COBRA continuation coverage for Qualified Beneficiaries other than the Employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered Employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the Qualifying Event (36 months minus 8 months). Otherwise, when the Qualifying Event is the end of employment or reduction of the Employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

A copy of the SSA disability determination letter must be provided to the McKee Foods Corporation Group Insurance Department within 60 days of receiving the disability determination or upon COBRA enrollment, whichever is later. Notification must be given prior to the end of the initial 18-month period. Failure to provide this notice in a timely manner may result in denial of the disability extension. If the SSA changes the determination and finds that the Qualified Beneficiary is no longer disabled, a copy of the revised determination must be provided to the McKee Foods Corporation Group Insurance Department within 30 days.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the

spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Payment Requirements

You must submit any payment required for COBRA continuation coverage to the Administrator at the address indicated on your payment notice. If you do not enroll when first becoming eligible, the payment due for the period between the date you first become eligible and the date you enroll for COBRA continuation coverage must be paid to the Employer within 45 days after the date you enroll for COBRA continuation coverage. After enrolling for COBRA continuation coverage, all payments are due and payable on a monthly basis, on the first of each month, with a 30-day grace period. Failure to make payment within the 30-day grace period will result in termination of COBRA continuation coverage without reinstatement.

How Long is COBRA Coverage Provided?

COBRA continuation coverage is available for a maximum of:

a. 18 months if the loss of coverage is caused by termination of employment or reduction in hours of employments; or
b. 29 months of coverage if the criteria for a disability extension is met; or
c. 36 months for other Qualifying Events. If a covered dependent is eligible for 18 months of COBRA continuation coverage as described above, and there is a second Qualifying Event (e.g. divorce), you may be eligible for 36 months of COBRA continuation coverage from the date of the first Qualifying Event.

When Will COBRA Continuation Coverage End?

After You have elected COBRA continuation coverage, that coverage will terminate either at the end of the applicable 18, 29 or 36 month eligibility period, or before the end of that period, upon the date that:

- The Employer ceases to provide a group health plan to any Employee; or
- Payment for such coverage is not submitted when due; or
- The date that You, otherwise eligible for 29 months of COBRA continuation coverage, are determined to no longer be disabled for purposes of the COBRA law; or
- You become covered as either a subscriber of dependent by another group health care plan, and that coverage is as good as or better than the COBRA continuation coverage.

However, a Qualified Beneficiary who becomes covered under a group health plan which has a preexisting conditions limit must be allowed to continue COBRA coverage for the length of a preexisting condition limit or to the COBRA maximum time period, whichever is less. COBRA coverage may be terminated if the Qualified Beneficiary becomes covered under a group health plan with a preexisting conditions limit (as defined in COBRA) if the preexisting conditions limit does not apply (or is satisfied by)

the Qualified Beneficiary by reason of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other more affordable coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage.

You should compare your other coverage options with COBRA continuation coverage and choose the coverage that is best for you. For example, if you move to other coverage you may pay more out of pocket than you would under COBRA because the new coverage may impose a new deductible.

When you lose job-based health coverage, it's important that you choose carefully between COBRA continuation coverage and other coverage options, because once you've made your choice, it can be difficult or impossible to switch to another coverage option.

You may be able to get coverage through the Health Insurance Marketplace that costs less than COBRA continuation coverage. You can learn more about the Marketplace below.

What is the Health Insurance Marketplace?

The Marketplace offers "one-stop shopping" to find and compare private health insurance options. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums and cost-sharing reductions (amounts that lower your out-of-pocket costs for deductibles, coinsurance, and copayments) right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Through the Marketplace you'll also learn if you qualify for free or low-cost coverage from Medicaid or the Children's Health Insurance Program (CHIP). You can access the Marketplace for your state at www.HealthCare.gov.

Coverage through the Health Insurance Marketplace may cost less than COBRA continuation coverage. Being offered COBRA continuation coverage won't limit your eligibility for coverage or for a tax credit through the Marketplace.

When can I enroll in Marketplace coverage?

You always have 60 days from the time you lose your job-based coverage to enroll in the Marketplace. That is because losing your job-based health coverage is a "special enrollment" event. **After 60 days, your special enrollment period will end and you may not be able to enroll, so you should take action right away.** In addition, during what is called an "open enrollment" period, anyone can enroll in Marketplace coverage.

To find out more about enrolling in the Marketplace, such as when the next open enrollment period will be and what you need to know about qualifying events and special enrollment periods, visit www.HealthCare.gov.

If I sign up for COBRA continuation coverage, can I switch to coverage in the Marketplace? What about if I choose Marketplace coverage and want to switch back to COBRA continuation coverage?

If you sign up for COBRA continuation coverage, you can switch to a Marketplace plan during a Marketplace open enrollment period. You can also end your COBRA continuation coverage early and switch to a Marketplace plan if you have another qualifying event such as marriage or birth of a child through something called a "special enrollment period." But be careful though - if you terminate your COBRA continuation coverage early without another qualifying event, you'll have to wait to enroll in Marketplace coverage until the next open enrollment period, and could end up without any health coverage in the interim.

Once you've exhausted your COBRA continuation coverage and the coverage expires, you'll be eligible to enroll in Marketplace coverage through a special enrollment period, even if Marketplace open enrollment has ended.

If you sign up for Marketplace coverage instead of COBRA continuation coverage, you cannot switch to COBRA continuation coverage under any circumstances.

Can I enroll in another group health plan?

You may be eligible to enroll in coverage under another group health plan (like a spouse's plan), if you request enrollment within 30 days of the loss of coverage.

If you or your dependent chooses to elect COBRA continuation coverage instead of enrolling in another group health plan for which you're eligible, you'll have another opportunity to enroll in the other group health plan within 30 days of losing your COBRA continuation coverage.

What factors should I consider when choosing coverage options?

When considering your options for health coverage, you may want to think about:

- Premiums: Your previous plan can charge up to 102% of total plan premiums for COBRA coverage. Other options, like coverage on a spouse's plan or through the Marketplace, may be less expensive.
- Provider Networks: If you're currently getting care or treatment for a condition, a change in your health coverage may affect your access to a particular health care provider. You may want to check to see if your current health care providers participate in a network as you consider options for health coverage.
- Drug Formularies: If you're currently taking medication, a change in your health coverage may affect your costs for medication – and in some cases, your medication may not be covered by another plan. You may want to check to see if your current medications are listed in drug formularies for other health coverage.

- Severance payments: If you lost your job and got a severance package from your former employer, your former employer may have offered to pay some or all of your COBRA payments for a period of time. In this scenario, you may want to contact the Department of Labor at 1-866-444-3272 to discuss your options.
- Service Areas: Some plans limit their benefits to specific service or coverage areas – so if you move to another area of the country, you may not be able to use your benefits. You may want to see if your plan has a service or coverage area, or other similar limitations.
- Other Cost-Sharing: In addition to premiums or contributions for health coverage, you probably pay copayments, deductibles, coinsurance, or other amounts as you use your benefits. You may want to check to see what the cost-sharing requirements are for other health coverage options. For example, one option may have much lower monthly premiums, but a much higher deductible and higher copayments.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

Plan: McKee Foods Corporation Employees Health and Supplemental Benefits Plan
Administered by McKee Foods Corporation

Group Insurance Department
PO Box 2078
Collegedale, TN 37315

(423) 238-7111, extension 22865 or (800) 338-7231

HIPAA

Notwithstanding anything in this Plan to the contrary, any component benefit program that is a Covered Entity shall be operated in accordance with the Privacy and Security Standards of HIPAA and their related regulations (the "HIPAA regulations"), including but not limited to, the Health Information Technology for Economic and Clinical health Act ("HITECH Act").

Employees of an Employer may have access to individually identifiable health information of Participants. This information is PHI.

Disclosures of PHI

Employees may disclose to an Employer information on whether an individual is participating in the Plan and, subject to the conditions described below and as otherwise permitted by law, may disclose PHI to Employers, provided the Employers use or disclose the PHI only for Plan administration purposes. Employees may disclose summary health information to McKee Foods Corporation if McKee Foods Corporation requests it in order to modify, amend, or terminate the Plan or any component benefit program.

On behalf of all Employers, McKee Foods Corporation, as Plan Administrator, agrees that, other than enrollment and disenrollment information and summary health information, all Employers will:

1. Not use or further disclose PHI other than as permitted or required by the Plan or any component benefit program, or as required by law;
2. Ensure that any agent, including a subcontractor, to whom it provides PHI received from the Plan or any component benefit program agrees in writing to the same restrictions and conditions that apply to Employers with respect to the PHI and to implement reasonable and appropriate safeguards to protect electronic PHI;
3. Not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of an Employer;
4. Report to the Plan any use or disclosure of PHI that is inconsistent with the permitted uses or disclosures of which it becomes aware;
5. Make PHI available to comply with HIPAA's right of access in accordance with the HIPAA regulations;
6. Make PHI available for amendment, and incorporate any amendments of PHI, in accordance with the HIPAA regulations;
7. Make available the information required to provide an accounting of disclosures in accordance with the HIPAA regulations;
8. Make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan or a component benefit program available to the Secretary of Health and Human Services in order to determine compliance by the Plan or any component benefit program with HIPAA's privacy requirements;
9. If feasible, return or destroy all PHI received from the Plan or a component benefit program that Employers still maintain in any form and retain no copies of the information when no longer needed for the purpose for which disclosure was made, except that, if the return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible;

10. Ensure that adequate separation between the Plan and component benefit programs and all Employers as required by the HIPAA regulations is satisfied;
11. If it creates, receives, maintains, or transmits any electronic PHI on behalf of the Plan or a component benefit program, implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI, and ensure that any agents to whom it provides such electronic PHI agree to implement reasonable and appropriate security measures to protect the information;
12. Report to the Plan and, if applicable, component benefit program any security incident of which it becomes aware; and
13. To the extent that an Employer uses or maintains electronic health records with respect to PHI, ensure that an individual has the ability to exercise his right to receive an accounting from the Employer of disclosures of the individual's electronic health records that have been made by the Employer in the three years prior to the individual's request for an accounting, including: (a) disclosures made to carry out health care treatment, payment, and operations; (b) disclosures not permitted by the privacy rule; (3) disclosures an Employer makes pursuant to a "public policy" purpose; (d) disclosures required by law; and (e) disclosures made pursuant to an administrative or judicial order, subpoena, discovery request, qualified medical child support order, or workers' compensation program.

Minimum Necessary

When using or disclosing PHI or when requesting PHI from another party, the Plan will make reasonable efforts to limit PHI to: (1) the minimum necessary to accomplish the intended purpose of the use or disclosure, or to satisfy the purpose of a request; or (2) a limited data set for purposes of health care operations.

Non-Compliance

In the event of non-compliance with any of the provisions set forth in this section, the HIPAA Privacy Officer will address any compliance issues promptly and confidentially by investigating the complaint and documenting their investigation efforts and findings. If PHI has been used or disclosed in violation of the Privacy Policy or inconsistent with this section, the HIPAA Privacy Officer shall take immediate steps to mitigate any harm caused by the violation and to minimize the possibility that such a violation will recur. If an authorized employee or other employee is found to have violated the Privacy Policy, the employee will be subject to disciplinary action up to and including termination of employment.

Discovery of Breach

Following the discovery of a breach of unsecured PHI, the Plan Administrator will notify each individual whose unsecured PHI has been, or is reasonably believed to have been, accessed, acquired, or disclosed as a result of the breach, in accordance with 45 C.F.R. Section 164.404, as amended, and will notify the Secretary of Health and Human Services in accordance with 45 C.F.R. Section 164.408, as amended. For a breach of unsecured PHI involving more than 500 residents of a state or jurisdiction, the Plan Administrator will notify the media in accordance with 45 C.F.R. Section 164.406, as amended. "Unsecured PHI" means PHI that is not secured through the use of technology or methodology specified in regulations or other guidance issued by the Secretary of Health and Human Services.

CLAIMS PROCEDURES

If a component benefit program has its own procedures governing how claims and appeals are processed under that program, then those procedures will apply. To the extent that a component benefit program does not have procedures governing how claims and appeals are processed under that program, then the following procedures will apply.

Submitting a Claim

A "Claim" is a request that benefits under the Plan be paid. A Claim is incurred on the date the services or supplies are provided.

The provider of services should submit Claims to the claims administrator for the applicable component benefit program. The claims administrator for each component benefit program is described in the Attachments.

All Claims must be submitted within three hundred sixty five (365) days after the Claim is incurred.

Group Health Plan Claims

"Group Health Plan Claims" are Claims under a component benefit program that is a Group Health Plan. There are four types of Group Health Plan Claims: Urgent Care Claims, Concurrent Care Claims, Pre-Service Claims, and Post-Service Claims.

Urgent Care Claims

An Urgent Care Claim is a request for the preauthorization of medical care or treatment where using the standard time frames for the preauthorization process could seriously jeopardize the claimant's life or health or ability to regain maximum function, or would, in the opinion of a physician with knowledge of the claimant's medical condition, subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Claim.

Urgent Care Claims are always Pre-Service Claims or Concurrent Care Claims to extend a previously-approved course of treatment that must be preauthorized by the Plan. Post-Service Claims are never Urgent Care Claims because the service has already been provided. Whether a Claim is an Urgent Care Claim is decided at the time the preauthorization request is being processed. If requested services are provided before the Claim for Preauthorization is processed, or while it is being processed, the Claim is no longer considered an Urgent Care Claim.

If the claimant submits an Urgent Care Claim that identifies the claimant, the medical condition, and the service involved to someone who is customarily responsible for handling benefit matters, but who is the wrong person to receive an Urgent Care Claim request, the Plan will advise the claimant of the proper procedures as soon as possible, but no later than 2 hours after receiving the Claim.

The Plan Administrator (or its designee) will notify the claimant of its decision on an Urgent Care Claim as soon as possible (whether adverse or not), taking into account the medical exigencies, but no later than 72 hours after the Plan's receipt of the Claim, unless the Claim is incomplete.

If a request for preauthorization is made to extend the course of treatment for Urgent Care beyond the time period or number of treatments originally approved, then the Plan Administrator (or its designee) will respond to the Claim as soon as possible, but no later than 24 hours after the Claim for preauthorization is received, if the Claim is filed at least 24 hours before expiration of the originally approved course of treatment.

If an Urgent Care Claim is incomplete, the Plan Administrator (or its designee) will notify the claimant of the information necessary to complete the Claim as soon as possible, but no later than 24 hours after the Plan receives the Claim. The claimant has a reasonable period of time (but not less than 48 hours) to provide the additional information. As soon as possible, but no more than 48 hours after the Plan receives the additional information, or after the claimant's deadline for providing the additional information, if earlier, the Plan Administrator (or its designee) will notify the claimant of its decision on the Claim. The Plan's decision may be provided orally, with a written or electronic notification furnished within 3 days.

If the Plan Administrator (or its designee) partially or completely denies the Claim for Urgent Care, the claimant may orally or in writing request an expedited appeal of the decision, and the Plan Administrator (or its designee) will notify the claimant of its decision on the appeal by telephone, facsimile or electronically as soon as possible, but not later than 72 hours after the appeal is filed.

Concurrent Care Claims

If the Plan has approved an ongoing course of treatment that will be provided over a period of time or will include a certain number of treatments, and the Plan Administrator (or its designee) decides to reduce or terminate the period of time or number of treatments, it will give notice to the claimant sufficiently in advance to allow the claimant to appeal the decision before the benefits are reduced or terminated.

Pre-Service Claims

A Pre-Service Claim is a request for a determination whether medical services are medically necessary in advance of the services where the Claim or benefit level will be denied if preauthorization is not obtained.

For a Pre-Service Claim, the Plan Administrator (or its designee) will notify the claimant of its decision (whether adverse or not) within a reasonable time period, but no later than 15 days after the Plan receives the Claim.

This 15-day period may be extended for another 15 days if the Plan Administrator (or its designee) determines that the extension is necessary due to matters beyond its control and it notifies the claimant during the initial 15-day period of the extension of the reason for the extension and the date by which the Plan expects to make a decision. If the extension is necessary because the claimant failed to submit necessary information, the Plan Administrator (or its designee) will also describe the additional information needed. The claimant will have at least 45 days from receipt of this notice to provide the requested information.

If the claimant submits a Pre-Service Claim that identifies the claimant, the medical condition and the service involved to someone who is customarily responsible for handling benefit matters, but is the

wrong person to receive a Pre-Service Claim, the Plan Administrator (or its designee) will advise the claimant of the proper procedures as soon as possible, but no later than 5 days after receiving the claim.

If the Plan Administrator (or its designee) partially or completely denies a Pre-Service Claim, the claimant may appeal the decision within 180 days of receiving the adverse decision, and the Plan Administrator (or its designee) will notify the claimant of its decision on the appeal within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after the appeal is filed.

Post-Service Claims

A Post-Service Claim is any Claim that is not an Urgent Care Claim, Concurrent Care Claim or Pre-Service Claim. The claimant is requesting reimbursement for or payment of care that has already been received.

The Plan Administrator (or its designee) will notify a claimant of its decision on a Post-Service Claim within a reasonable time period, but no later than 30 days after the Claim is received.

This 30-day period may be extended for another 15 days if the Plan Administrator (or its designee) determines that the extension is necessary due to matters beyond its control, and the Plan Administrator (or its designee) notifies the claimant during the initial 30-day period of the extension, the reason for the extension, and the date by which the Plan expects to make a decision. If the extension is necessary because the Claim is incomplete, the Plan Administrator (or its designee) will also describe the additional information necessary to complete the Claim. The claimant will have at least 45 days from receipt of this notice to provide the requested information.

If the Plan Administrator (or its designee) partially or completely denies a Post-Service Claim, the claimant may appeal the decision within 180 days of receiving the adverse decision, and the Plan Administrator (or its designee) will notify the claimant of its decision on the appeal within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after the appeal is filed.

Other Non-Health Claims

The Plan Administrator (or its designee) will notify a claimant of its decision on a Claim that is not a Group Health Plan Claim or a Disability Claim within a reasonable time period, but no later than 90 days after the Claim is received.

This 90-day period may be extended for an additional 90 days if the Plan Administrator (or its designee) determines that special circumstances require an extension of time for processing the Claim, and the Plan Administrator (or its designee) notifies the claimant during the initial 90-day period of the extension and provides a reason for the extension and the date by which the Plan expects to make a decision.

If the Plan Administrator (or its designee) partially or completely denies a Claim that is not a Group Health Plan Claim or a Disability Claim, the claimant may appeal the decision within 60 days of receiving the adverse decision, and the Plan Administrator (or its designee) will notify the claimant of its decision on the appeal within a reasonable period of time, but not later than 60 days after the appeal is filed.

Internal Appeals Procedures

Full and Fair Review On Internal Appeal

During a Claim Appeal, the Plan Administrator (or its designee):

1. Will provide claimants with the opportunity to submit written comments, documents, records, and other information relating to the Claim;
2. Will provide that the claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information "relevant" to the claimant's Claim; and
3. Will provide for a review that takes into account all comments, documents, records, and other information submitted by the claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial benefit determination.

During a Claim Appeal for a Group Health Plan Claim, in addition to the items listed above, the Plan Administrator (or its designee):

1. Will provide for a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;
2. Will provide that, in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;
3. Will provide that the health care professional engaged for purposes of a consultation under the above provision shall be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual; and
4. Will, upon request, provide for the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

During a Claim Appeal for a Group Health Plan Claim, in addition to the items listed above, the Plan Administrator (or its designee):

1. Will allow the claimant to review the Claim file and to present evidence and testimony as part of the internal claims and appeals process;
2. Will provide the claimant, free of charge and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required to be provided in order to give the claimant a reasonable opportunity to respond, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the Claim;

3. Will provide the claimant, free of charge and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required to be provided in order to give the claimant a reasonable opportunity to respond, with any new or additional rationale; and
4. Will, for an Urgent Care Claim, provide an expedited review process pursuant to which: (a) a request for an expedited appeal of an adverse benefit determination may be submitted orally or in writing by the claimant; and (b) all necessary information, including the Plan's benefit determination on review, shall be transmitted between the Plan and the claimant by telephone, facsimile, or other available similarly expeditious method.

Definition of Relevant

Information is "relevant" to a claim for purposes of this section if:

1. it was relied on to decide the Claim;
2. it was submitted, considered or generated while deciding the Claim, whether or not it was relied upon;
3. it demonstrates compliance with the administrative processes used to verify that Claim decisions are made in accordance with the Plan documents and that Plan provisions have been applied consistently to similarly situated individuals; or
4. it is a statement of policy or guidance regarding the treatment denied for the claimant's diagnosis, whether or not it was relied on.

Rescission of Coverage

If the Plan Administrator (or its designee) rescinds a claimant's health plan coverage retroactively in a Rescission, the claimant may appeal that decision under these Appeal procedures and the external review procedures below, even if the Rescission does not have a negative adverse effect on any particular benefit at the time of the Rescission.

General Rules Applicable to Internal Claims and Internal Appeals

If the provisions of this "CLAIMS PROCEDURES" section apply, the Plan Administrator (or its designee) will have the sole discretion to make the determination of all internal Claims and Appeals. Benefits will be paid only if the Plan Administrator (or its designee) decides in its full and absolute discretion that the claimant is entitled to benefits.

The time period for making an initial or Appeal Claim decision shall begin on the date a Claim or Appeal is filed in accord with the Plan's claims procedures, whether or not all the information necessary to make a decision has been filed. If a decision time period is extended because the claimant must submit more information, the decision time period is tolled from the date the claimant is notified that more information is needed until the claimant provides the additional information; provided, however, that if the claimant does not provide any additional information within 45 days from receipt of the notice that additional information is necessary, the Plan Administrator may make an initial or Appeal Claim decision.

Decisions regarding the hiring, compensation, termination, promotion, or other similar matters regarding persons who are involved in making Claims and Appeals decisions (e.g., claims adjudicators and medical experts) will not be based upon the likelihood that the individual will support the denial of benefits.

If the Plan Administrator (or its designee) denies a claimant's initial Claim for benefits or Appeal, the written or electronic denial will include in a culturally and linguistically appropriate manner:

1. The specific reasons for the adverse decision or denial;
2. Reference to the specific Plan provision on which the decision is based;
3. A description of any information necessary to complete the Claim, and an explanation of why the information is needed;
4. For an initial denial of a Claim, a description of the Plan's internal review procedures and external review processes, including information regarding how to initiate an Appeal, the time limits for an Appeal, and a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA only following exhaustion or deemed exhaustion of the internal Claim and Appeal procedures; and
5. For a denial on Appeal, a discussion of the decision, a statement of the claimant's right to external review and to bring an action under Section 502(a) of ERISA only following exhaustion or deemed exhaustion of the internal Claim and Appeal procedures.

If the Plan Administrator (or its designee) denies a claimant's initial Claim for benefits or Appeal for a Claim that was a Group Health Plan Claim, in addition to the above items, the denial will include:

1. Any specific internal rule, guideline, protocol, standard or criterion relied on in making the decision, or a statement that a criterion was relied on and will be provided free of charge upon request; and
2. For any decision based on the requirement that services be medically necessary or the exclusion of experimental or investigative services, an explanation of the scientific or clinical judgment for the decision, applying the Plan terms to the claimant's medical circumstances, or a statement that the explanation will be provided free of charge upon request.

If the Plan Administrator (or its designee) denies a claimant's initial Claim for benefits or Appeal for a Claim that was a Group Health Plan Claim, in addition to the above items, the denial will include:

1. Information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;
2. The denial code and its corresponding meaning, as well as a description of the of the Plan's standard, if any, that was used in denying the Claim;
3. A description of available internal appeals (for initial Claim denials) and external review processes, including information regarding how to initiate an appeal; and
4. The availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established to assist individuals with the internal claims and appeals and external review processes.

If the Plan Administrator (or its designee) fails to adhere to the regulatory requirements for claims processing:

1. The claimant is deemed to have exhausted the internal Claims and Appeals processes of the Plan, unless the failure is de minimis and it does not cause and is not likely to cause prejudice or harm to the claimant, so long as the Plan Administrator (or its designee) demonstrates that the

failure was for good cause or due to matters beyond the control of the Plan and the failure occurred in the context of an ongoing, good faith exchange of information between the Plan Administrator (or its designee) and the claimant, and the failure was not part of a pattern or practice of violations by the Plan Administrator (or its designee);

2. The claimant is entitled to pursue any available remedies under ERISA, including, where applicable an external review; and
3. The Claim or Appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary.

The claimant may request from the Plan Administrator (or its designee) a written explanation of the violation of the regulatory requirements for claims processing, and the Plan Administrator (or its designee) will provide it within ten days, including the Plan Administrator's (or its designee's) basis for asserting that the violation should not cause the internal Claims and Appeals process to be deemed exhausted.

If an external reviewer or court rejects the claimant's request for immediate review because the Plan Administrator's (or its designee's) failure was de minimis, the claimant may resubmit the Claim and pursue the internal Appeal of the Claim. Within ten days of the decision of the external reviewer or court to reject the Claim for immediate review, the Plan will notify the claimant of the claimant's right to resubmit the Claim for internal Appeal. The time period for re-filing the Claim begins to run upon claimant's receipt of the notice.

External Review Procedures for Group Health Plan Claims

A claimant may file a request for External Review of a Group Health Plan Claim with the Plan if the request is filed within four months after receipt of a notice of an adverse benefit determination on the claimant's internal Appeal if the adverse benefit determination involves a Rescission of coverage or a medical judgment, including, but not limited to, medical necessity, appropriateness, health care setting, level of care or effectiveness of a covered benefit, or a determination that a treatment is experimental or investigative.

If there is no corresponding date four months after the date the denial is received, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

A denial, reduction, termination or failure to pay a benefit based on a determination that a participant does not meet the eligibility requirements of the Plan is not eligible for External Review.

Preliminary Review of Request for External Review

Within five business days following receipt of the External Review request, the Plan Administrator (or its designee) must complete a preliminary review of the request to determine whether:

1. The claimant is or was covered under the Plan at the time the health care item or service was requested or provided;
2. The Claim denial is eligible for External Review;

3. The claimant has exhausted the Plan's internal Claims and Appeal process (or, the claimant is deemed to have exhausted the internal Claims and Appeal process); and
4. The claimant has provided all the information and forms required to process an External Review.

Within one business day after completing the preliminary review, the Plan Administrator (or its designee) must notify the claimant of its findings in writing. If the request is complete but not eligible for External Review, the notification must include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, the notification must describe the information or materials needed to make the request complete, and the Plan must allow the claimant to perfect the request for External Review within the four-month filing period or within the 48-hour period following the claimant's receipt of the notification, whichever is later.

Referral to Independent Review Organization

The Plan Administrator (or its designee) will assign an independent review organization ("IRO") that is accredited by URAC or by a similar nationally-recognized accrediting organization to conduct the external review. The Plan Administrator, or its designee, will rotate claims assignments among its IRO's (or incorporate other independent, unbiased methods for selection of IRO's, such as random selection). The IRO will not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits. The assigned IRO will utilize legal experts where appropriate to make coverage determinations under the Plan.

The assigned IRO will timely notify the claimant in writing that the claimant's request is eligible for External Review and that it has been accepted for External Review. This notice will include a statement that the claimant may submit additional information in writing to the assigned IRO within ten business days following receipt of the notice, and that the IRO will consider the information when conducting the External Review. The IRO is not required to, but may, accept and consider additional information submitted after ten business days.

Within five business days after the IRO is assigned to the claim, the Plan Administrator (or its designee) will provide to the assigned IRO the documents and information considered in making the benefit determination. If the Plan Administrator (or its designee) fails to timely provide the documents and information, the assigned IRO may terminate the External Review and reverse the adverse benefit determination. Within one business day after making this decision, the IRO will notify the claimant and the Plan Administrator (or its designee).

If the IRO receives any information from the claimant, the IRO must within one business day forward the information to the Plan Administrator (or its designee). Upon receipt of the information, the Plan Administrator (or its designee) may reconsider its adverse benefit determination that is the subject of the External Review. The External Review will be terminated as a result of the Plan's reconsideration only if the Plan decides to reverse its adverse benefit determination and provide coverage or payment. Within one business day after making such a decision, the Plan Administrator (or its designee) must provide written notice of its decision to the claimant and the assigned IRO. The assigned IRO will terminate the External Review upon receipt of the notice from the Plan Administrator (or its designee).

The IRO will review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the Claim de novo and not be bound by any decisions or conclusions reached during the Plan's internal Claim or Appeal process.

In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

1. The claimant's medical records;
2. The attending health care professional's recommendation;
3. Reports from appropriate health care professionals and other documents submitted by the Plan, claimant, or the claimant's treating provider;
4. The terms of the Plan, to ensure that the IRO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law;
5. Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, or national or professional medical societies, boards, and associations;
6. Any applicable clinical review criteria developed and used by the Plan Administrator (or its designee), unless the criteria are inconsistent with the terms of the Plan or with applicable law; and
7. The opinion of the IRO's clinical reviewer or reviewers after considering the information and documents available, to the extent the clinical reviewer or reviewers consider appropriate.

The assigned IRO will provide written notice of the final External Review decision within 45 days after the IRO receives the request for the External Review. The IRO will deliver the notice of final External Review decision to the claimant and the Plan.

The assigned IRO's decision will contain:

1. A general description of the reason for the request for External Review, including information sufficient to identify the Claim, including the date or dates of service, the health care provider, the Claim amount (if applicable), and the reason for the previous denial;
2. The date the IRO received the assignment to conduct the External Review and the date of the IRO decision;
3. References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
4. A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
5. A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the Plan or to the claimant;
6. A statement that judicial review may be available to the claimant; and
7. Current contact information, including the phone number, for any applicable office of health insurance consumer assistance or ombudsman established under Public Health Service Act Section 2793.

Record Retention

After a final External Review decision, the IRO will maintain records of all Claims and notices associated with the External Review process for six years. The IRO will make these records available for examination by the claimant, the Plan, or a State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws.

Reversal of Plan's Decision

Upon receiving a final External Review decision reversing an adverse benefit determination, the Plan will immediately provide coverage or immediately pay the Claim.

Expedited External Review of an Urgent Care Claim

A claimant may request an expedited External Review of an Urgent Care Claim if the claimant receives:

1. An initial Claim denial for a medical condition of the claimant for which the timeframe for completion of an expedited internal Appeal would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function, and the claimant has filed a request for an expedited internal appeal; or
2. A denial on Appeal if the claimant has a medical condition where the timeframe for completion of a standard External Review would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function, or if the final Appeal denial concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services, but has not been discharged from a facility.

Immediately upon receipt of the request for expedited External Review, the Plan Administrator (or its designee) will determine whether the request meets the reviewability requirements for External Review. The Plan will immediately send to the claimant a notice of its decision that meets the requirements set forth in the "*Preliminary Review of Request for External Review*" section above for standard External Review.

Upon a determination that a request is eligible for External Review, the Plan will assign an IRO pursuant to the requirements set forth in the "*Referral to Independent Review Organization*" section above for standard review. The Plan Administrator (or its designee) will provide to the assigned IRO all necessary documents and information considered in making the adverse benefit determination, by telephone or facsimile or electronically or by any other available expeditious method. The assigned IRO will consider the information or documents described above under the procedures for standard review.

The IRO will provide notice of the final external review decision, in accordance with the requirements set forth in the *"Referral to Independent Review Organization*" section above, as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited External Review. If the notice is not provided in writing, then within 48 hours after the date of providing the notice, the IRO will provide written confirmation of the decision to the claimant and the Plan Administrator (or its designee).

Claims Litigation

If an individual's claim has been partially or completely denied, and the individual has exhausted all applicable internal and external claims and appeals procedures under this "CLAIMS PROCEDURES" section of the Plan or a component benefit program's relevant claims and appeals procedures, as applicable, the individual may bring an action under Section 502(a) of ERISA. However, no such legal action may be brought more than three (3) years following the date of the first decision on the claim.

PARTICIPANT RIGHTS

Rights under ERISA

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the plan, including insurance contracts and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials

were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Rights under the Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Rights under the Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this Plan.

Rights under USERRA

If you are returning from uniformed service, you have certain rights with respect to the Plan pursuant to USERRA. In addition, special health care continuation coverage rules may apply while you are performing military service. Contact the Plan Administrator for more information.

Rights under FMLA

If you take a leave of absence that is covered by the FMLA, you may be able to continue your health coverage during your leave. Coverage will only be continued if you continue to pay premiums for coverage. If you drop your health coverage during the leave, you can have your health coverage reinstated on the date you return to work, if you apply for coverage within 30-days of your return to work and pay any contributions required for the coverage. Contact the Plan Administrator for more information.

MISCELLANEOUS

Recovery of Overpayments

If, for any reason, any benefit under the Plan is erroneously paid or exceeds the amount appropriately payable under the Plan, the Participant or Dependent shall be responsible for refunding the overpayment to the Plan. In addition, if the Plan makes any payment that, according to the terms of the Plan, should not have been made, the Plan Administrator may recover that incorrect payment, whether or not it resulted from the Plan Administrator's own error, from the person to whom it was made or from any other appropriate party. As may be permitted in the sole discretion of the Plan Administrator, the refund or repayment may be made in one or a combination of the following methods: (1) in the form of a single lump-sum payment; (2) as a reduction of the amount of future benefits otherwise payable under the Plan; (3) as automatic deductions from pay; or (4) any other method as may be required or permitted in the sole discretion of the Plan Administrator. The Plan may also seek recovery of the erroneous payment or benefit overpayment from any other appropriate party to the fullest extent permitted by applicable law.

Misrepresentation

Intentional misrepresentation of any material fact with respect to the Plan may result in termination of a Participant's eligibility to participate in the Plan.

Rescissions

The Plan Administrator may retroactively cancel or discontinue coverage under any component benefit program that is subject to the provisions of the Affordable Care Act upon 30 days' notice if a Participant performs an act, practice, or omission that constitutes fraud or makes an intentional misrepresentation of material facts. The Plan Administrator may also retroactively cancel or discontinue coverage under any component benefit program if the Participant fails to pay required premiums or contributions toward the cost of coverage.

Claims Litigation

If an individual's claim has been partially or completely denied, and the individual has exhausted all applicable internal and external claims and appeals procedures under the "CLAIMS PROCEDURES" section of the Plan or a component benefit program's relevant claims and appeals procedures, as applicable, the individual may bring an action under Section 502(a) of ERISA. However, no such legal action may be brought more than three (3) years following the date of the first decision on the claim.

No Contract of Employment

This Plan is not intended to be and shall not be construed as a contract of employment for any person.

No Vested Rights

No employee of an Employer, Participant, or Dependent shall at any time have any vested rights to benefits provided under the Plan or under any component benefit program.

Severability

If any provision of this Plan is held invalid or unenforceable, such invalidity or unenforceability shall not affect any other provision, and the Plan shall be construed and enforced as if such provision had not been included.

No Trust

To the extent any component benefit program is self-insured by any Employer, the benefits provided will be paid solely from the general assets of the Employer. Nothing herein will be construed to require the Employer or the Plan Administrator to maintain any fund or segregate any amount for the benefit of any Participant in this Plan, and no Participant or other person shall have any claim against, right to, or security or other interest in, any fund, account, or asset of the Employer from which any self-insured benefit payment under the Plan may be made.

Governing Law

The Plan shall be governed and administered in accordance with ERISA and other applicable federal laws. If ERISA or other federal law requires or permits any provision of the Plan to be governed by or interpreted according to state law, the laws of the State of Tennessee shall apply without regard to its conflicts-of-law principles.

GENERAL PLAN INFORMATION

Plan Name

McKee Foods Corporation Employees Health and Supplemental Benefits Plan

Plan Number

501

Plan Year

January 1 – December 31

Employer Information

McKee Foods Corporation
P.O. Box 750
Collegedale, TN 37315
(423) 238-7111

Plan Administrator Information

McKee Foods Corporation
P.O. Box 2078
Collegedale, TN 37315
(423) 238-7111

Plan Sponsor EIN

62-0450611

Type of Plan and Source of Funding

The Plan is an unfunded welfare benefit plan that includes medical, prescription drug, dental, vision, health reimbursement, wellness, employee assistance, critical illness, and group accident components. Contributions are made by employees and the employer.

Type of Administration

Benefits are administered by the employer, a third-party claims administrator, or an insurance company

Agent for Service of Legal Process

McKee Foods Corporation
Attention: Law Department
P.O. Box 750
Collegedale, TN 37315

ATTACHMENTS

Summary Plan Description for McKee Foods Corporation and Participating Employers

Attachment A: Medical Program

Attachment B: Prescription Drug Program

Attachment C: Health Reimbursement Arrangement Program ("HRA Program")

Attachment D: Wellness Program

Attachment E: Dental Program

Attachment F: Vision Program

Attachment G: Employee Assistance Program ("EAP Program")

Attachment H: Critical Illness Program

Attachment I: Group Accident Program

Attachment J: McKeeFlex Program (McKee Foods Corporation Section 125 Flexible Spending Program)

Note: A separate summary plan description is provided for employees of Prairie City Bakery, LLC.

RESTATEMENT
OF THE
MCKEE FOODS CORPORATION
EMPLOYEES HEALTH AND SUPPLEMENTAL BENEFITS PLAN

(Effective January 1, 2019)

The McKee Foods Corporation Employees Health and Supplemental Benefits Plan (the "Plan"), including the Attachments thereto, are hereby amended and restated as set out in the attached documents. The restatement is generally effective January 1, 2019; provided, however, Attachment K, the Prairie City Bakery, LLC Section 125 Flexible Spending Plan, is effective May 3, 2019.

MCKEE FOODS CORPORATION

By: _____
Mike McKee, President and CEO

Date: 7-24-19

39361604.1

ATTACHMENT B

PRESCRIPTION DRUG PROGRAM

This Attachment sets forth the terms under which prescription drug benefits will be offered to eligible Participants and eligible Dependents. The Plan has entered into an agreement with a pharmacy benefit manager that has contracted with certain pharmacies for prescription drug services.

MCKEE FOODS CORPORATION EMPLOYEES

HEALTH AND SUPPLEMENTAL BENEFITS PLAN

PRESCRIPTION DRUG PROGRAM

Amended and Restated Effective: January 1, 2019

10181 SCRIPPS GATEWAY CT.
San Diego, CA 92131
(888) 728-5030
www.medimpact.com

MEMBER ADVOCATES

MedImpact Healthcare System's Customer Service team is available to assist you 24 hours a day, 7 days a week, 365 days a year

Toll Free (888) 728-5030

ELIGIBILITY

A Participant or Dependent is eligible to participate in the benefits provided under this Attachment B if the Participant or Dependent is participating in one of the Medical Program options described in Attachment A. An eligible Participant and Dependent will be automatically enrolled in the Prescription Drug benefits provided under this Attachment, without the need to separately elect Prescription Drug coverage. Prescription Drug benefits cannot be elected separately from the Medical Program benefits described in Attachment A.

COVERAGE TIERS

Prescriptions covered by the Plan are categorized in three separate tiers as listed below.

Type of Medication	**Tier**
Generic	Tier 1
Preferred Formulary Brand	Tier 2
Non-Preferred Brand	Tier 3

Your Plan has a separate benefit for specialty mediations. Specialty medications treat chronic complex conditions such as Rheumatoid Arthritis, Cancer, Multiple Sclerosis, Hepatitis C, Crohn's Disease, Bleeding Disorders, Asthma, Psoriasis, and more. Specialty prescriptions covered by the Plan are categorized into three separate specialty tiers as listed below.

Type of Medication	**Tier**
Specialty Generic	Tier 1
Specialty Preferred Brand	Tier 2
Specialty Non-Preferred Brand	Tier 3

Your financial responsibility for each tier is based upon the benefits offered by your Plan. For more information regarding your coverage and estimated drug costs, visit the Benefit Information section of the MedImpact's website at www.MedImpact.com or call the MedImpact Customer Service at (888) 728-5030.

PRESCRIPTION DRUG SCHEDULE OF BENEFITS: $1,350 HRA

BENEFIT DESCRIPTION	BENEFIT	
RX DEDUCTIBLE – CALENDAR YEAR	**IN-NETWORK**	**OUT-OF-NETWORK****
Single	None	
Family	None	
OUT-OF-POCKET MAXIMUM – CALENDAR YEAR	**IN-NETWORK**	**OUT-OF-NETWORK****
Single	$4,050	$8,100
Family	$8,100 Not to exceed $7,900 per individual	$16,200
RETAIL PHARMACY (30-DAY SUPPLY)		
Tier 1 – Generic (Preferred Pharmacy)	$3	50%
Tier 1 – Generic (In-Network Pharmacy)	$9	50%
Tier 2 – Preferred Brand	20%	50%
Tier 3 – Non-Preferred Brand	40%	50%
RETAIL PHARMACY (90-DAY SUPPLY)		
Tier 1 – Generic (Preferred Pharmacy)	$6	50%
Tier 1 – Generic (In-Network Pharmacy)	$12	50%
Tier 2 – Preferred Brand	20%	50%
Tier 3 – Non-Preferred Brand	40%	50%
MAIL ORDER PHARMACY (30-DAY SUPPLY)		
Tier 1 – Generic	$3	n/a
Tier 2 – Preferred Brand	20%	n/a
Tier 3 – Non-Preferred Brand	40%	n/a
MAIL ORDER PHARMACY (90-DAY SUPPLY)		
Tier 1 – Generic	$0	n/a
Tier 2 – Preferred Brand	20%	n/a
Tier 3 – Non-Preferred Brand	40%	n/a
SPECIALTY PHARMACY (30-DAY SUPPLY)*		
Tier 1 – Specialty Generic	15% up to $200 max	50%
Tier 2 – Specialty Preferred Brand	25% up to $300 max	50%
Tier 3 – Specialty Non-Preferred Brand	40% up to $400 max	50%
VARIABLE COPAYMENT: Copays for certain specialty medications may be set higher than the standard copayment for specialty drugs in order to benefit from maximum coupon assistance from manufacturer programs to help reduce your pharmacy costs. Your actual copayment will be adjusted to your regular specialty medication copayment so your actual out-of-pocket amount will remain the same or lower.		
ACA PREVENTIVE MEDICATIONS (30-DAY SUPPLY) ♦		
	No cost	
NOTES:	For medications on the Safe Harbor Preventive list, the cost for medications do not apply towards deductible, only out-of-pocket limit.	

	For medications not on the Safe Harbor Preventive list, the costs for medications will apply toward deductible and out-of-pocket limit. * If you are using a co-pay or savings card for specialty medication, you will only receive credit for the amount you pay after the co-pay or savings card is applied. ** Out Of Network prescription claims processed via member submission of Paper Claims for Direct Member Reimbursement (DMR). ♦ Refer to ACA/Essential Health Benefit (EHB) Medication drug list available on the Benefits Portal at work or benefits.mckee.com from home.

If Brand drug is requested when there is a generic equivalent, the member cost will be the difference between the Brand cost and the Generic Cost.

**For any new script, members will be required to fill two 30-day supply prescriptions before a 90-day is available.

PRESCRIPTION DRUG SCHEDULE OF BENEFITS: $1,350 HSA

BENEFIT DESCRIPTION	BENEFIT	
DEDUCTIBLE – CALENDAR YEAR	**IN-NETWORK**	**OUT-OF-NETWORK****
Combined with medical Single Family	 $1,350 $2,700	 $2,600 $5,200
OUT-OF-POCKET MAXIMUM – CALENDAR YEAR	**IN-NETWORK**	**OUT-OF-NETWORK****
Combined with medical – includes deductible Single Family	 $4,050 $8,100 Not to exceed $7,900 per individual	 $8,100 $16,200
RETAIL PHARMACY (30-DAY SUPPLY)		
Tier 1 – Generic (Preferred Pharmacy)	$3	50%
Tier 1 – Generic (In-Network Pharmacy)	$9	50%
Tier 2 – Preferred Brand	20%	50%
Tier 3 – Non-Preferred Brand	40%	50%
RETAIL PHARMACY (90-DAY SUPPLY)		
Tier 1 – Generic (Preferred Pharmacy)	$6	50%
Tier 1 – Generic (In-Network Pharmacy)	$12	50%
Tier 2 – Preferred Brand	20%	50%
Tier 3 – Non-Preferred Brand	40%	50%
MAIL ORDER PHARMACY (30-DAY SUPPLY)		
Tier 1 – Generic	$3	n/a
Tier 2 – Preferred Brand	20%	n/a
Tier 3 – Non-Preferred Brand	40%	n/a
MAIL ORDER PHARMACY (90-DAY SUPPLY)		
Tier 1 – Generic	$0	n/a
Tier 2 – Preferred Brand	20%	n/a
Tier 3 – Non-Preferred Brand	40%	n/a
SPECIALTY PHARMACY (30-DAY SUPPLY)*		
Tier 1 – Specialty Generic	15% up to $200 max	50%
Tier 2 – Specialty Preferred Brand	25% up to $300 max	50%
Tier 3 – Specialty Non-Preferred Brand	40% up to $400 max	50%
ACA PREVENTIVE MEDICATIONS (30-DAY SUPPLY) ♦		
	No cost	
NOTES:	For medications on the Safe Harbor Preventive list, the deductible is waived and members will pay the co-pay or coinsurance rate. The amount paid does not apply towards the deductible, but will apply towards the out-of-pocket limit. For medications not on the Safe Harbor Preventive list, the member will pay the full cost of the medication and the costs will apply	

	toward deductible and out-of-pocket limit. Once deductible is met, the member will pay the co-pay or coinsurance rate. * For Specialty medication, members will pay full price until deductible is met. Once the deductible is met, members will pay the coinsurance rate up to the coinsurance maximum. If you are using a co-pay or savings card for specialty medication, you will only receive credit for the amount you pay after the co-pay or savings card is applied. **Out Of Network prescription claims processed via member submission of Paper Claims for Direct Member Reimbursement (DMR). ♦ Refer to ACA/Essential Health Benefit (EHB) Medication drug list available on the Benefits Portal at work or benefits.mckee.com from home.

If Brand drug is requested when there is a generic equivalent, the member cost will be the difference between the Brand cost and the Generic Cost.

**For any new script, members will be required to fill two 30-day supply prescriptions before a 90-day is available.

PRESCRIPTION DRUG SCHEDULE OF BENEFITS: $1,750 HSA

BENEFIT DESCRIPTION	BENEFIT	
DEDUCTIBLE – CALENDAR YEAR	**IN-NETWORK**	**OUT-OF-NETWORK****
Combined with medical Single Family	 $1,750 $3,500	 $3,500 $7,000
OUT-OF-POCKET MAXIMUM – CALENDAR YEAR	**IN-NETWORK**	**OUT-OF-NETWORK****
Combined with medical – includes deductible Single Family	 $5,250 $10,500 Not to exceed $7,900 per individual	 $10,500 $21,000
RETAIL PHARMACY (30-DAY SUPPLY)		
Tier 1 – Generic (Preferred Pharmacy)	$3	50%
Tier 1 – Generic (In-Network Pharmacy)	$9	50%
Tier 2 – Preferred Brand	20%	50%
Tier 3 – Non-Preferred Brand	40%	50%
RETAIL PHARMACY (90-DAY SUPPLY)		
Tier 1 – Generic (Preferred Pharmacy)	$6	50%
Tier 1 – Generic (In-Network Pharmacy)	$12	50%
Tier 2 – Preferred Brand	20%	50%
Tier 3 – Non-Preferred Brand	40%	50%
MAIL ORDER PHARMACY (30-DAY SUPPLY)		
Tier 1 – Generic	$3	n/a
Tier 2 – Preferred Brand	20%	n/a
Tier 3 – Non-Preferred Brand	40%	n/a
MAIL ORDER PHARMACY (90-DAY SUPPLY)		
Tier 1 – Generic	$0	n/a
Tier 2 – Preferred Brand	20%	n/a
Tier 3 – Non-Preferred Brand	40%	n/a
SPECIALTY PHARMACY (30-DAY SUPPLY)*		
Tier 1 – Specialty Generic	15% up to $200 max	50%
Tier 2 – Specialty Preferred Brand	25% up to $300 max	50%
Tier 3 – Specialty Non-Preferred Brand	40% up to $400 max	50%
ACA PREVENTIVE MEDICATIONS (30-DAY SUPPLY) ♦		
	No cost	
NOTES:	For medications on the Safe Harbor Preventive list, the deductible is waived and members will pay the co-pay or coinsurance rate. The amount paid does not apply towards the deductible, but will apply towards the out-of-pocket limit. For medications not on the Safe Harbor Preventive list, the member will pay the full cost of the medication and the costs will apply	

	toward deductible and out-of-pocket limit. Once deductible is met, the member will pay the co-pay or coinsurance rate. * For Specialty medication, members will pay full price until deductible is met. Once the deductible is met, members will pay the coinsurance rate up to the coinsurance maximum. If you are using a co-pay or savings card for specialty medication, you will only receive credit for the amount you pay after the co-pay or savings card is applied. **Out Of Network prescription claims processed via member submission of Paper Claims for Direct Member Reimbursement (DMR). ♦ Refer to ACA/Essential Health Benefit (EHB) Medication drug list available on the Benefits Portal at work or benefits.mckee.com from home.

If Brand drug is requested when there is a generic equivalent, the member cost will be the difference between the Brand cost and the Generic Cost.

**For any new script, members will be required to fill two 30-day supply prescriptions before a 90-day is available.

PRESCRIPTION DRUG SCHEDULE OF BENEFITS: $2,500 HSA

BENEFIT DESCRIPTION	BENEFIT	
DEDUCTIBLE – CALENDAR YEAR	**IN-NETWORK**	**OUT-OF-NETWORK****
Combined with medical		
Single	$2,500	$5,000
Family	$5,000	$10,000
OUT-OF-POCKET MAXIMUM – CALENDAR YEAR	**IN-NETWORK**	**OUT-OF-NETWORK****
Combined with medical – includes deductible		
Single	$6,750	$13,500
Family	$13,500 Not to exceed $7,900 per individual	$27,000
RETAIL PHARMACY (30-DAY SUPPLY)		
Tier 1 – Generic (Preferred Pharmacy)	$3	50%
Tier 1 – Generic (In-Network Pharmacy)	$9	50%
Tier 2 – Preferred Brand	20%	50%
Tier 3 – Non-Preferred Brand	40%	50%
RETAIL PHARMACY (90-DAY SUPPLY)		
Tier 1 – Generic (Preferred Pharmacy)	$6	50%
Tier 1 – Generic (In-Network Pharmacy)	$12	50%
Tier 2 – Preferred Brand	20%	50%
Tier 3 – Non-Preferred Brand	40%	50%
MAIL ORDER PHARMACY (30-DAY SUPPLY)		
Tier 1 – Generic	$3	n/a
Tier 2 – Preferred Brand	20%	n/a
Tier 3 – Non-Preferred Brand	40%	n/a
MAIL ORDER PHARMACY (90-DAY SUPPLY)		
Tier 1 – Generic	$0	n/a
Tier 2 – Preferred Brand	20%	n/a
Tier 3 – Non-Preferred Brand	40%	n/a
SPECIALTY PHARMACY (30-DAY SUPPLY)*		
Tier 1 – Specialty Generic	15% up to $200 max	50%
Tier 2 – Specialty Preferred Brand	25% up to $300 max	50%
Tier 3 – Specialty Non-Preferred Brand	40% up to $400 max	50%
ACA PREVENTIVE MEDICATIONS (30-DAY SUPPLY) ♦		
	No cost	
NOTES:	For medications on the Safe Harbor Preventive list, the deductible is waived and members will pay the co-pay or coinsurance rate. The amount paid does not apply towards the deductible, but will apply towards the out-of-pocket limit. For medications not on the Safe Harbor Preventive list, the member will pay the full cost of the medication and the costs will apply toward deductible and out-of-pocket limit.	

	Once deductible is met, the member will pay the co-pay or coinsurance rate. * FOR SPECIALTY MEDICATION, MEMBERS WILL PAY FULL PRICE UNTIL DEDUCTIBLE IS MET. ONCE THE DEDUCTIBLE IS MET, MEMBERS WILL PAY THE COINSURANCE RATE UP TO THE COINSURANCE MAXIMUM. IF YOU ARE USING A CO-PAY OR SAVINGS CARD FOR SPECIALTY MEDICATION, YOU WILL ONLY RECEIVE CREDIT FOR THE AMOUNT YOU PAY AFTER THE CO-PAY OR SAVINGS CARD IS APPLIED. **Out Of Network prescription claims processed via member submission of Paper Claims for Direct Member Reimbursement (DMR). ♦ Refer to ACA/ESSENTIAL HEALTH BENEFIT (EHB) MEDICATION drug list available on the Benefits Portal at work OR benefits.mckee.com from home.

If Brand drug is requested when there is a generic equivalent, the member cost will be the difference between the Brand cost and the Generic Cost.

**For any new script, members will be required to fill two 30-day supply prescriptions before a 90-day is available.

DIABETES PROGRAM

By enrolling in the Diabetes Program, you will receive certain diabetic medications and supplies at any in-network pharmacy at a reduced co-pay or reduced coinsurance. If you are enrolled in one of the HSA Medical plans, you will not receive the reduced co-pay or coinsurance until your deductible is met. Note that non-preferred brand drugs or supplies do not receive any discount.

Tier 1 – Generic	Tier 2 – Preferred Brand*	Tier 3 – Non-preferred Brand*
In-network pharmacy benefits	**In-network pharmacy benefits**	**In-network pharmacy benefits**
$1 co-pay for 30-day supply $2 co-pay for 90-day supply $0 co-pay for 90-day supply via mail order or preferred pharmacy	10% coinsurance	40% coinsurance

If Brand drug is requested when there is a generic equivalent, the member cost will be the difference between the Brand cost and the Generic Cost.

COPAYMENTS AND COINSURANCE

You are responsible for paying the Copayment and/or Coinsurance amounts as indicated (at the time of purchase, if the pharmacy submits the claim electronically).

PRESCRIPTION MEDICATION CALENDAR YEAR DEDUCTIBLE

This Deductible includes both costs from your medical and prescription expenses. Costs in excess of the Covered Prescription Medication Expense that are charged by an out of network pharmacy do not count toward the in-network Deductible.

PRESCRIPTION MEDICATION CALENDAR YEAR OUT-OF-POCKET MAXIMUM

This Out-of-Pocket Maximum includes both costs from your medical and prescription expenses.

Your Copayments and/or any Coinsurance for Prescription Medications obtained from a Participating Pharmacy will be waived during the remainder of a Plan Year once Your Out-of-Pocket Maximum amount is met.

GENERIC MEDICATIONS

Generics have the same active ingredients in the same dose as brand-name drugs and have been approved by the Food and Drug Administration (FDA) to be safe and effective. Generic drugs generally cost less than brand-name drugs. These savings are passed on to you when you receive a generic medication. Talk to your doctor or pharmacist to see if a generic (Tier 1) drug is right for you.

COVERED PREFERRED FORMULARY BRAND MEDICATIONS

Preferred brand medications are drugs that are covered by your Plan at the preferred formulary brand copay/coinsurance rate.

COVERED NON-PREFERRED BRAND MEDICATIONS

Non-preferred brand medications are drugs that are covered by your Plan, but at a higher cost to you. Non-preferred brand medications may have a generic equivalent available, or there may be another brand medication that is used to treat the same condition that is generally more cost effective without compromising quality.

SPECIALTY MEDICATIONS

Specialty medications treat chronic complex conditions such as Rheumatoid Arthritis, Cancer, Multiple Sclerosis, Hepatitis C, Crohn's Disease, Bleeding Disorders, Asthma, Psoriasis, and more. These high cost drugs come in many forms and may be taken orally, injected with a syringe and needle, or even inhaled with a nebulizer. These medications require special handling or a higher level of support than traditional medications. Your specialty medication can be delivered to your home, your provider's office, or any approved location.

PREVENTIVE MEDICATIONS

One element of the Affordable Care Act is the coverage of certain preventive medications at no cost to the member. As required by law, these medications are covered by the Plan at no cost to you when age and gender appropriate, prescribed by a health care professional, and filled at a network pharmacy. Types of preventive medications include:

- Contraceptives: including; oral, vaginal, transdermal, and injectable.
- Emergency contraception
- Fluoride
- Aspirin
- Folic Acid
- Certain Vitamins
- Smoking Cessation Medications
- Immunizations

Refer to ACA/ESSENTIAL HEALTH BENEFIT (EHB) MEDICATION drug list available on the Benefits Portal at work OR benefits.mckee.com from home.

MedImpact has determined that contraceptives containing the same progestin are equivalent to each other. Each unique progestin contraceptive medication is represented as a Preventive Care Medication to ensure women have access to a broad range of contraceptives at no cost. All other contraceptives may be covered in other tiers at the applicable copay.

Unless specifically stated, medications available over-the-counter (OTC) without a prescription are not covered by the Plan.

FORMULARY DRUG LIST DEVELOPMENT & CHANGES

The current Formulary Products List is available on the Benefits Portal at work OR benefits.mckee.com from home.

The MedImpact Pharmacy and Therapeutics Committee may, in its professional judgment, modify Medications and supplies on the Formulary Products List as follows:

- Place products on the Prescription Drug Formulary and remove products from the Prescription Drug Formulary.
- Place products on the Prior Authorization List and remove products from the Prior Authorization List.

- Categorize Non-Prescription Products (over-the-counter products) as a Covered Expense, according to Covered Expenses as listed in the Base Plan Document, the Medical Program or another Attachment.
- Place Medications into and remove Medications from the Specialty Pharmacy Program.
- Place and remove limitations or restrictions on products based on clinical best practice as published in peer reviewed literature. This includes quantity limits, age limits, concurrent therapy, and other administration methods to provide clinically appropriate products to Members or Dependents.
- Exclude medications from coverage based on factors such as FDA-labeled use, other available therapies, safety concerns, or waiting for sufficient broad-population utilization data on new medications.

Actions by the Pharmacy and Therapeutics Committee take place quarterly, as medical technology evolves, as indications change, or as FDA (Food and Drug Administration) guidelines change. The Pharmacy Benefits Administrator, MedImpact, will inform Members and Dependents of the actions taken by the Pharmacy and Therapeutics Committee as appropriate, including when benefits under this Plan are affected.

DRUGS WITH SPECIAL REQUIREMENTS

Your health, safety, and well-being are important. MedImpact works closely with your doctor in order to ensure that you are taking the right medication at the right time. Preauthorization, step therapy, and clinical edits are some of the strategies that MedImpact uses. For a list of drugs that have specific requirements, visit the Benefit Information section of the MedImpact website at www. MedImpact.com.

- **Prior Authorization** Some medications require prior authorization and are only approved for certain conditions. Your doctor must submit a prior authorization request to MedImpact to determine coverage. Once MedImpact has reviewed the request, your doctor will be notified of the decision, typically within 48 hours. If the request is approved, MedImpact will work with the pharmacy to get the prescription ready for you to pick up. If the request is denied, a representative of MedImpact will contact you to discuss the decision, provide alternative coverage if available, and provide direction for follow up with your doctor.
- **Step Therapy** Other medications require step therapy, which means that you must have tried and failed other medications that treat the same condition and are generally more cost effective without compromising quality. Step therapy may be waived (with a prior authorization request) if determined to be medically necessary. The use of samples does not waive the step therapy requirement.
- **Quantity Limits** Quantity Limits are placed on certain medications to ensure that the amounts prescribed are within the recommended dosages specified by the Food and Drug Administration (FDA). Quantity limits are set to ensure appropriate use and safety. Limits can be accumulative which means that the number of pills or units dispensed will be counted over time and across strengths and formulations of the same medication or medications that treat the same condition.

Your physician can request an exception to quantity limits and step therapy through the prior authorization process.

DRUGS NOT COVERED ON THE FORMULARY

The McKee Foods formulary has been designed to ensure members have access to needed medications while controlling costs to preserve the Plan benefits. Certain medications are not covered on the formulary. Medications are not covered if they have not been approved by the FDA, are over-the-counter (OTC), or if a clinical equivalent medication is available at a lower cost. Coverage consideration for a drug that is not covered would be made by appeal and review of medical records only.

FILLING A PRESCRIPTION

You have multiple options to obtain your prescriptions.

- **Retail:** When your prescription is filled at a retail pharmacy, you may receive either a 30-day or 90-day supply. McKee Foods has designated "preferred" pharmacies where members can receive reduced costs if they get prescriptions filled at these locations. To locate a "preferred" pharmacy, please visit the Benefits Portal at work OR benefits.mckee.com from home. To locate other in-network participating pharmacy, contact a MedImpact Customer Service at (888) 728-5030 or visit the MedImpact website at www.MedImpact.com.
- **Mail Order:** By using the mail order benefit, you can receive a 30-day or 90-day supply of your prescription delivered to your home at no additional charge. To learn more about mail order visit the mail service page on the MedImpact website at www.MedImpact.com or call MedImpact Direct Pharmacy at (888) 728-5030.
- **Specialty:** MedImpact Direct Specialty is the preferred specialty provider with MedImpact. If you are using a Specialty Medication, please contact a MedImpact Direct Specialty Customer Service Representative at (888)728-5030 for additional details. Each fill of a Specialty Medication may be for up to a 30-day supply.

In order to fill a prescription for a 90-day supply (through Retail or Mail Order), your prescriber must write your prescription for a 90-day supply. Please note that you will be required to fill two 30-day supply prescriptions before a 90-day supply is available.

MEDIMPACT PARTICIPATING PHARMACY NETWORK

You can use your MedImpact pharmacy benefits at more than 65,000 participating pharmacies. The MedImpact network includes national pharmacy chains, local and regional chains, many independent pharmacies, and specialty pharmacies. To find out if your pharmacy is participating, visit www.MedImpact.com or call MedImpact at (888) 728-5030.

McKee Foods has designated "preferred" pharmacies where members can receive reduced costs if they get prescriptions filled at these locations. To locate a "preferred" pharmacy, please visit the Benefits Portal at work OR benefits.mckee.com from home.

Make sure to present your Insurance ID card that includes the MedImpact logo with your prescription. If you use a pharmacy that is not in the MedImpact network or you do not present your Insurance ID card, you will be required to pay the full cost of the prescription and then submit for reimbursement. If the prescription is covered, you will be reimbursed the contracted rate, less any applicable deductible or copay/coinsurance. In most cases, the pharmacy's cash price is more than MedImpact's contracted rate,

which will leave you responsible to pay for an additional amount. To avoid paying any unnecessary expenses, make sure to use a participating pharmacy.

MEDIMPACT SECURE WEBSITE

You can learn more about your prescription benefits online. Visit www.MedImpact.com to register your information and log into the secure member portal. You can find the following helpful information and tools on the MedImpact website:

Benefit Information

- Prescription copay information
- Estimated drug costs
- Prescription claim history report
- Find a participating pharmacy
- Find a list of covered drugs as well as those that have special requirements

Order Mail Order Prescriptions Online

- Register for home delivery mail order through MedImpact Direct
- View order status
- Request a refill

Customer Support

- **View and print a temporary prescription ID Card**
- Print a member reimbursement form
- Contact MedImpact

COORDINATION OF BENEFITS

Coordination of Benefits is when you have coverage through more than one insurance company and they work together to pay for a prescription. This Plan does allow for coordination of benefits on pharmacy claims as listed in the Medical Program (See Attachment A).

COVERED PRESCRIPTION MEDICATIONS

- Diabetic supplies (including test strips, glucagon emergency kits, and insulin syringes, but not insulin pumps and their supplies), when obtained with a Prescription Order (insulin pumps and their supplies are covered under the Durable Medical Equipment benefit);
- Prescription Medications;
- Certain preventive medications (including, but not limited to, aspirin, fluoride, iron and Generic Medications for tobacco use cessation) according to, and as recommended by, the United States Preventive Service Task Force (USPSTF), when obtained with a Prescription Order;
- Women's contraception methods as recommended by the Health Resources and Services Administration (HRSA);
- Immunizations for adults and children according to, and as recommended by, the Centers for Disease Control and Prevention (CDC);
- Specialty Medications;
- Self-Administrable Cancer Chemotherapy Medication (all Prescription Medications for Self-Administrable Cancer Chemotherapy Medications must be provided by a Specialty Pharmacy). See below for Special Provisions for Cancer Drug Treatment Regimen; and

- Self-Administrable Prescription Medications (including, but not limited to, Self-Administrable Compound and Injectable Medications).

EXCLUSIONS

In addition to the Exclusions in the Medical Program, the following exclusions apply to this Prescription Medication Benefits Section, unless otherwise specifically defined by the Claims Administrator:

Acne Medication

Prescription Medications for the treatment of acne in Claimants over age 39.

Biological Sera, Blood or Blood Plasma, Plasma-derived and Recombinant Clotting Factor Products

Certain Contraceptives

Prescription contraceptives that cannot be self-administered, including Norplant, surgically inserted contraceptive devices, IUDs, and Depo-Provera (coverage for these contraceptives may otherwise be provided under the Medical Program). Abortifacient medications.

Cosmetic Purposes

Prescription Medications used for cosmetic purposes, including, but not limited to: removal, inhibition, or stimulation of hair growth; retardation of aging; or repair of sun-damaged skin.

Devices or Appliances

Devices or appliances of any type, other than insulin pumps, even if they require a Prescription Order (coverage for devices and appliances may otherwise be provided under the Medical Program).

Foreign Prescription Medications

Except for Foreign Prescription Medications associated with an Emergency Medical Condition while traveling outside the United States, or those purchased while residing outside the United States, the Plan does not cover foreign Prescription Medications. These exceptions apply only to medications with an equivalent FDA-approved Prescription Medication that would be covered under this section if obtained in the United States.

Insulin Pumps and Pump Administration Supplies

Coverage for insulin pumps and supplies is provided under the Medical Program.

Medications That Are Not Considered Self-Administrable

Coverage for these medications may otherwise be provided under the Medical Program.

Non-prescription Medications

Medications that by law do not require a Prescription Order and which are not included in the Claims Administrator's definition of Covered Prescription Medications, shown below, unless included on the Formulary.

Off-Label Use Prescription Medications

Prescription Medications that have not yet received FDA approval for the purpose and in the manner they are being prescribed. However, if a Prescription Drug is prescribed for other than its FDA-approved use

and is recognized as effective for the use for a particular diagnosed condition, benefits for the Prescription Drug may be provided when so used, as determined by the Plan.

Prescription Medications Dispensed in a Facility
Prescription Medications dispensed while a patient in a Hospital, Skilled Nursing Facility, nursing home or other health care institution. Medications dispensed upon discharge should be processed under this Prescription Drug benefit if obtained from a Pharmacy.

Prescription Medications Dispensed in Connection with Participation in a Clinical Trial

Prescription Medications for Treatment of Impotence, including Sexual Dysfunction Devices or Medications

Prescription Medications for Treatment of Infertility

Prescription Medications Not Dispensed by a Pharmacy Pursuant to a Prescription Order

Prescription Medications Not within a Provider's License
Prescription medications prescribed by providers who are not licensed to prescribe medications (or that particular medication) or who have a restricted professional practice license.

Prescription Medications with No FDA-Proven Therapeutic Indication

Prescription Medications without Examination
Prescriptions made by a provider without a recent and relevant in-person examination of the patient, whether the prescription order is provided by mail, telephone, internet or some other means.

Professional Charges for Administration of Any Medication

Weight Loss Medications
MedImpact and McKee Foods reserves the right to modify the Exclusion List. There may be other Exclusions not listed above, please contact MedImpact at (888) 728-5030 if you have questions about a certain medications.

APPEALS PROCEDURES

Requests for coverage or appeals relating to the Prescription Drug benefit should be sent in writing along with any other pertinent information you wish MedImpact to review in conjunction with your appeal. Send all information to:

MedImpact Healthcare Systems
Attn: Appeals & Grievance
10181 Scripps Gateway Court
San Diego, CA 92131

Non-urgent appeals will be decided by MedImpact within a reasonable period of time, but not later than fifteen (15) calendar days after MedImpact receives the appeal and supporting documentation. Urgent appeals will be reviewed within 72 hours.

If your appeal is denied, MedImpact will provide written notification to you or your authorized representative. Written notification will include:

1. The specific reason(s) for the denial;
2. Reference to the specific Plan provision on which the adverse benefit determination was based;

Requests for coverage or appeals relating eligibility should be sent in writing along with any other pertinent information you wish McKee Foods to review in conjunction with your eligibility appeal. Send all information to:

McKee Foods Insurance Review Committee
PO Box 2078
Collegedale, TN 37315

SECOND LEVEL APPEAL

If your request for coverage appeal relating to the Prescription Drug benefit is denied, you or your authorized representative may request further review by MedImpact. This request for a second-level appeal must be made, in writing, within one hundred eighty (180) days of the date you are notified of the original appeal decision.

MedImpact will promptly conduct a full and fair review of your appeal, independently from the individual(s) who considered your first level appeal or anyone who reports to such individual(s) and without affording deference to the initial denial.

Second-level appeals will be decided by MedImpact within a reasonable period of time, but not later than fifteen (15) calendar days after MedImpact receives the appeal and supporting documentation. MedImpact's decision will be provided to you in writing, and if the decision is a second denial, the notification will include all of the information described above.

If your request for an eligibility appeal is denied, you or your authorized representative may request further review by McKee Foods. This request for a second-level appeal must be made, in writing, within sixty (60) days of the date you are notified of the original appeal decision. Send all information to:

McKee Foods Insurance Appeals Board
PO Box 2078
Collegedale, TN 37315

VOLUNTARY EXTERNAL APPEAL – IRO

A voluntary Appeal to an Independent Review Organization (IRO) is available, but only after you have exhausted all of the applicable non-voluntary Appeals, or if MedImpact has failed to adhere to all claims

and internal Appeal requirements. Voluntary external Appeals must be requested within one hundred eighty (180) days of your receipt of the notice of the prior adverse decision.

MedImpact will coordinate voluntary external appeals, and the decision is made by an IRO at no cost to you. MedImpact will provide the IRO with the appeal documentation. The IRO will make its decision and provide you with its written determination. Choosing the voluntary external appeal as the final level to determine an appeal will be binding in accordance with the IRO's decision and this Attachment B, except to the extent other remedies are available under federal law.

The voluntary external appeal by an IRO is optional, and you should know that other forums may be utilized as the final level of appeal to resolve a dispute you have under the Plan.

Additional information about claims and claims procedures can be found in the Base Document. Where there is an inconsistency between this Attachment B and the Base Document, this Attachment B shall control.

ADDITIONAL INFORMATION ON PRESCRIPTION BENEFITS

For more information about these Prescription benefits, please call the Pharmacy Benefits Manager, MedImpact at (888) 728-5030, or visit the website at www.MedImpact.com.

EXHIBIT B

MedImpact
One Source. Lower Cost. Better Care.™

June 3, 2019

SENT VIA FACSIMILE (423) 396-6947
AND OVERNIGHT DELIVERY

Thrifty MedPlus Pharmacy
5032 Ooltewah Ringgold Rd., Ste. 100
Ooltewah, TN 37363

Pharmacy Providers of Oklahoma (PPOK)
45 NE 52nd St.
P.O. Box 18204
Oklahoma City, OK 73105

Re: Notice of Network Termination – McKee Foods Pharmacy Network
Thrifty Med Plus Pharmacy – NCPDP# 4436792 (the "Pharmacy")

Dear Pharmacy Owner/Manager:

The above referenced Pharmacy has been participating in the MedImpact Healthcare Systems, Inc. ("MedImpact") networks under the MedCare Pharmacy Network Agreement ("Agreement") between MedImpact and Pharmacy Providers of Oklahoma (PPOK) ("PSAO"). Pursuant to the MedCare Pharmacy Networks Policies and Procedures Manual ("Provider Manual"), the Pharmacy may be excluded or removed from participating in a network with respect to any specific Plan's networks (See Section 4.1 – Network Participation). As such, this letter serves as notice that the Pharmacy will be terminated from the pharmacy networks for McKee Foods **effective July 1, 2019**, and will no longer be able to submit claims for McKee Foods members after 11:59 p.m. PT on June 30, 2019.

The removal of the Pharmacy as a network provider will be applicable to only those networks utilized for McKee Foods and does not affect the participation of the Pharmacy in any other MedImpact network. Please be advised, however, that MedImpact reserves its rights and remedies under the Agreement with respect to the Pharmacy's continued participation in the remaining MedImpact networks.

Should you have any questions concerning this notice, please do not hesitate to contact us in writing.

Regards,
MedImpact Healthcare Systems, Inc.

Pharmacy Network Administration
PharmacyOperationsSups@medimpact.com

For your reference, the Provider Manual and Guidelines for Audits and Appeals are available online at
https://mp.medimpact.com/pharmacyportal/public/Frameset.jsp?forwardUrl=/pharmacyportal/public/PoliciesProcedures.jsp